Meaningful Use Workgroup
Transcript
July 3, 2012

Presentation

MacKenzie Robertson – Office of the National Coordinator

Good morning everybody. This is MacKenzie Robertson in the Office of the National Coordinator. Can everyone just be sure to mute their phones, I've got interference. Thanks. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup. This is a public call and there will be time for public comment at the end. The call is also being transcribed so please make sure you identify yourself before speaking. I will now take roll. Paul Tang?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Paul. George Hripcsak? I know George is on; he might just be on mute. Michael Barr?

Michael Barr – American College of Physicians

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Michael. David Bates?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks David. Christine Bechtel.

Eva Powell – National Partnership for Women and Families

This is Eva in for Christine.

MacKenzie Robertson – Office of the National Coordinator

Thanks Eva. Neil Calman?

Neil Calman –The Institute for Family Health – President and Cofounder

Here.

MacKenzie Robertson – Office of the National Coordinator

Hi Neil. Tim Cromwell? Art Davidson? He'll be joining a little bit later. Marty Fattig?

Marty Fattig – Nemaha County Hospital

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Marty. Joe Francis? Leslie Kelly Hall?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks Leslie. Yael Harris? David Lansky? Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks Deven. Greg Pace?

Greg Pace – Social Security Administration – Deputy CIO
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks Greg. Latanya Sweeney? Robert Tagalicod? Charlene Underwood?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks Charlene. Amy Zimmerman?

Amy Zimmerman – Rhode Island Department of Health & Human Services
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks Amy. Is there any staff on the line?

Michelle Nelson - Office of the National Coordinator
Michelle Nelson, ONC.

MacKenzie Robertson – Office of the National Coordinator
Thanks Michelle.

Josh Seidman – Office of the National Coordinator
Josh Seidman, ONC.

MacKenzie Robertson – Office of the National Coordinator
Thanks Josh.

Emma Potter – Office of the National Coordinator
Emma Potter, ONC.

MacKenzie Robertson – Office of the National Coordinator
Thanks Emma. Okay Paul, I'll turn it over to you.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO
Wonderful, thank you and thanks everyone for joining, and I know some people are leaving one of our…meetings for this as well. We have a full agenda and we actually have a full months' work ahead of us. So, by August 1, which is the next full committee…well, the meeting after the one next week, we need to present our preliminary recommendations for the first time, in front of the full Policy Committee for their feedback. Recall that we're headed towards a May 2013 final recommendations to ONC in order to meet their timeline and in preparation for that, we are trying to get an RFC out by November 6th, so that's what's driving our timeline.

So between now and the first, we need to come up with our best preliminary recommendations, and the work ahead of us is: One, on this call to finish up subgroup one, which is the first category, to hopefully finish up also subgroup 3 and start working on subgroup 4. And, at the end I want to talk about sort of an impact maker, you know that we have our principles that we agreed upon last year in terms of how to look at the Stage 3. And I thought I'd put together sort of a matrix that we put in front of us and measure up each of the things that we've been recommending along the way, and see how it measures up against our principles, so that we end up with a meaningful and impactful Stage 3 that both meets our goals, but also doesn't stress the system so much that people fall off the escalator. So that's sort of where we're headed and we only have two calls to…this call and then two more calls to get from here to that point, and so that's why we're maintaining our pace.

So today, we're going to be, as I said, finishing up with category 1 and then also hopefully completing category 3 and start working on category 4. Anything else to contribute to the agenda for today, or any questions on the overall timeline? Okay, well let's work on category 1, and I believe the matrix that was sent out this morning starts with where we left off, which is progress notes. And David, do you want to walk us through that?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Sure, is that going to show up on the screen?

Caitlin Collins – Altarum Institute

We can put it up there for you.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I had thought it was going to.

MacKenzie Robertson – Office of the National Coordinator

Yeah, it's just going to take a minute Art, I mean David, sorry. Does everyone see it now?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, thank you.

Michelle Nelson - Office of the National Coordinator

Thank you.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

You have that David?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I do. Although it's not legible on my screen here. So, I'm just trying to make it bigger and make it legible. Okay, so, our comments on this were that we were hoping that by Stage 3 we would have an electronic discharge summary. We talked about shortening the time interval to getting that to some period like 4 calendar days, but the issue is that for transitions, you need it immediately and our thought was that for long term care it should probably be within one…the same day as discharge. Long-term care facilities want it the same day as discharge. And, I think those were the main points. Now note that this was not included in Stage 2, even though we asked it to be. So, let me just stop there and ask for comments.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, this is Charlene. This is from the Care Coordination Group, so one of the areas that we'd had some feedback on, and maybe Leslie knows this, was…or actually what we put in our requirements was that on transition or on referral, that the data that is available is made available immediately. But the one piece of this discharge summary that we want, and again, if more data came in update it, but, the one piece of this element that is being asked for is the, the physician often at the end of the discharge, makes an abbreviated statement that describes the course of care plus changes in the care plan, just kind of a summary piece of information. And, that seems to be kind of a vital piece of information that gets communicated early on. So, it may be less than the full discharge summary, but certainly an important piece of information that gets communicated early on in the process. So, Leslie was going to look…I think our intention was to try to get that into Stage 2, I'm not sure it ever made it, but, that's one of the requirements that we put in the care coordination piece.

George Hripcsak – Columbia University

This is George; can you hear me?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

George Hripcsak – Columbia University

This is the objective for electronic notes, right. So, I mean I think the gist of it is if they don't electronic notes in Stage 2, then we're going to put it on again for Stage 3 for the most part.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And at the minimum for the discharge piece.

George Hripcsak – Columbia University

No, I'm saying that we would put it forward to all electronic notes, like we did in Stage 1 and 2, we're going to still put it forward to Stage 3.

M

Yeah, I think we should do…I agree, for everything.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is Leslie and I agree, and I think it's very hard to build an electronic…a health record of the future if we don't start building notes of some kind and I think it is disappointing that it's not in Stage 2, to have some notes entered, because we could then build upon that in the future. So the discharge is at a minimum.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yup.

George Hripcsak – Columbia University

But we don't…so we need to see the results of Stage…so our recommendation is that we should do Stage 2 and perhaps increase the percentage or not, depending on what they do…what the final rule says about Stage 2.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

And then maybe make the modifications that I suggested. In other words, shortening the…perhaps shortening the time interval and for transitions, asking for it immediately.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Sound reasonable?

M

Yes.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, what's not a transition if it's at discharge?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Well…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Referral.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

If somebody's just going home, it's not quite as urgent as if they're going to say a long-term care facility.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Now there is the one pager that's required anyway, and that sounds like it would…I mean, you know, the thing that's filled out, would that qualify? Do we have a specification for…I think there's probably a Joint Commission specification for that one pager.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I don't think we got into that level of detail.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Sounds like that's what Charlene was describing.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yes, I think so.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Right, we want to make sure at a minimum there is the note with the instructions for discharge for transition of care. That's the minimum note, but…

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I think that is a requirement for Joint Commission though.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Not within…not immediately, it's 24 hour and it can be based upon the 24 hours dictated by…it's dictated within 24 hours for Joint Commission, not actually recorded electronically and transition.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

No, what I'm saying is, there's a discharge summary, and that has it's timeline, but there's also a discharge instructions, which has some bare minimum things like the diagnosis and meds and stuff, and that's a requirement. That's typically, in the paper world of course, its hand filled out, because that's the only way you can get it immediately, as the patient is leaving. And I think what we're proposing is to have that available electronically, so there is a counterpart is what…I think that's what I'm trying to point out, if anybody else can verify whether that's a Joint Commission…or we can do that as homework.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I think discharge instructions are required when you're discharged; but the piece that we wanted to add in was kind of what physicians are trained to do, the synopsis. It may not be a full context of a discharge summary, but that abbreviated statement that says, kind of here's what happened in the course of care and this is what changed in the treatment plan…

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

…could be what's being asked for, so, I don't know if it's the whole...we didn't want to get stuck in the whole concept that it has to be this whole discharge summary.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. So, as homework group, maybe someone, maybe the Office could help us look up the Joint Commission's requirement for this discharge document, because I think it actually has what Charlene's just describing.

George Hripcsak – Columbia University

It's nothing that goes under this objective, right. That discussion was under group 2, patient engagement and group 3, care coordination. This objective is about the daily progress notes and the visit notes, which don't necessarily have a transition after them or anything…

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Well, there's some overlap here George.

George Hripcsak – Columbia University

Oh definitely, definitely; but we're going to be talking about care transitions in a minute, so, I don't know that I want to…I guess we could…we could rewrite it so that the discharge instructions, discharge summary and all that stuff is in this objective, and pull it out of the other ones, or at least make sure they're coordinated.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So I think George's question is, Charlene, is this…is what's stated here already in the care coordination?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

We have…we referred it actually back, at least the minimum, to get that information. We didn't refer back everything had to be electronic, so we referred it back to this section.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

We have that statement in ours that the minimum of transition, but then we referred it back.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So I almost think this is a separate requirement, whichever category we put it in, this is separate from the title, which is really the electronic documentation. And we're trying to make sure that if it doesn't make Stage 2, that we're getting Stage 3. As a separate thing, we want this transition document…a timely transition document. So that wherever we put it, it sounds like it's a different topic than the one that is…than this page 2.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I agree with that, we just wanted to make sure the other was covered. So, should we move on.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yup. So, for ONC, I think we're saying this is a different…it's another objective.

Michelle Nelson - Office of the National Coordinator

Okay.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

We'll clean it up afterwards. Thank you.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Can we go on to the next page?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Sure.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay, so…this next one relates to clinical lab results and the objective was not included in Stage 2, and we wanted to reconfirm our initial recommendation about this, we think it's an important one and we would like to see the threshold raised in Stage 3, and we're considering a threshold of something like 70%. And this is something that would be helpful for rural practices. So, comments here?

Marty Fattig – Nemaha County Hospital

This is Marty. Tell me about how this helps rural practices.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Many of them have relationships with little hospitals and if hospitals are required to send labs out, that will be a big win for them.

Marty Fattig – Nemaha County Hospital

It's a big win for the medical practice, it's a lose-lose for the hospital because they can't compete with the reference labs then, because the reference labs do not have to have that interface.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I don't think that's accurate, I think the reference labs do have to have the interface, too.

Marty Fattig – Nemaha County Hospital (NCHNET)

They're not covered under meaningful use.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Most of them already have electronic interfaces.

Marty Fattig – Nemaha County Hospital

Well, some do, yeah.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And most commercial labs have to send it to so many different EMRs today, that they've really…this is Leslie, they have overcome that or they're sending to fax servers where an EMR doesn't exist. So, if a hospital is a commercial…acting as a commercial lab, like 50% of their business, they are doing this in some degree, probably based upon an HL7 standard and at a PDF form, but not based upon LOINC.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Right. I think that's the issue. This is Charlene.

Marty Fattig – Nemaha County Hospital

Yeah. I can assure you this is not happening in rural Nebraska. I think it's an honorable goal, but…

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

But we're trying to use this lever to help even rural Nebraska form the data they need for population management, which will happen across the country, right?

Marty Fattig – Nemaha County Hospital (NCHNET)

Well, it'll only happen if people get on board and actually become a test for Stage 1, and, my…

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I also think they are directly or indirectly helped, because if an HIE acts as the lab interface back to smaller organizations for instance, you will have had a very low cost and interoperable way to handle lab results.

Amy Zimmerman – Rhode Island Department of Health & Human Services

I also…this is Amy. I think we have to remember this is a couple of years out, so, will this help us drive…I mean, thinking about today versus thinking three years from now.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

It's even four actually.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I think it'll be pretty readily achievable, and all the surveys that we've done looking at data exchange, this is by far the easiest type of data to exchange.

Marty Fattig – Nemaha County Hospital

Yeah, it really is, because, I mean, it's structured data is what's come across, so it is one of the easiest to exchange. I agree with the goal, I just worry about my colleagues coming along.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Sure.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Well I think Amy's point is a good one. We all agree that this is a goal, not just for me please, it's really a facilitator for population management and, as we say, we're trying to give a 3-1/2 year advance notice, basically.

George Hripcsak – Columbia University

So the…this is George. The threshold depends on what final rule…like Stage 2 we're still waiting, so, if we have Stage 2 as 40, Stage 3 could be 70. If Stage 2 is nothing, then Stage 3 could still be 70 or some other number. We have a lot of time to adjust that threshold.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Exactly, I agree with that.

Marty Fattig – Nemaha County Hospital

I'm not concerned about the threshold once people get on board, I mean, it's just going to be an all or nothing thing, but…

George Hripcsak – Columbia University

Well this threshold is for the hospital sending, not for the provider receiving.

Marty Fattig – Nemaha County Hospital

That's my point. Yeah, exactly, I mean, once...they're not send some and send others.

George Hripcsak – Columbia University

Well, the hospital may have to not send some, because the provider may not be able to accept the structured data yet.

Marty Fattig – Nemaha County Hospital

Um hm.

George Hripcsak – Columbia University

So the limiting factor is in that hospital's area are providers not doing meaningful use yet.

Marty Fattig – Nemaha County Hospital

Well, that shouldn't be the hospital's problem if they're not.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So let's…I think we're fairly…we have a fairly good consensus, and remember, we're many stages in terms…many phases in terms of getting this to our final recommendation. So, this is just putting a stake in the ground for the full committee discussion.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay.

Marty Fattig – Nemaha County Hospital

Sounds good.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

So, let's move on. We have several new ones, and Paul, do you want me to go through those.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes please.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay. So the first one is the ability to capture data from functional status scales; and we believe that functional status should be treated as an assessment, not a demographic variable. And there are lots of reasons for which this is important.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

This is something we pegged even in our Stage 1 days as a placeholder.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yes.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Now, one of the things I believe Michelle we're asking HIT Standards Committee, and by the way, what's going to come out of this call is a list of requests over to the Standards Committee's workgroups as far as are there standards for, in this case, functional status and other cases we've looked at gender identity, etcetera. That list will be produced after this call and then sent over to the Standards.

Neil Calman –The Institute for Family Health – President and Cofounder

This is Neil, is Christine on?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Eva's here for her.

Neil Calman –The Institute for Family Health – President and Cofounder

This came up in the discussion of one of the subgroups. There's a difference between functional status, this is one of the things we discussed; there's a difference between functional status, which basically I would agree is part of a clinical assessment, and what we were talking about in relationship to sort of the demographics, which is more, what are the specific needs, if any, of patients coming for care. Are they visually impaired, are they hearing impaired, do they have disabilities, which limit their access to the facility, things that would be relevant to sort of the caregiving process. Can they be phoned? Stuff like that. So, that's what I think we were trying to do is to differentiate those kinds of values from sort of the functional assessment piece, just so we don't think of them as the same.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, and I wonder if we call that functional limitations. This was an alternative to talking about disability.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

And that would be a good addition, if we're going to make that an addition, it would be helpful to have a specific list and maybe...I don't know if there is a standard list like that; it seems to me like there should be, but I don't know what it is.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

You're speaking on the disability side.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yes.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

Neil Calman –The Institute for Family Health – President and Cofounder

Yeah, I think, but that's what we were thinking of, and we weren't trying to make functional status where you're doing a real functional assessment as part of the demographic.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

So, as far as I can tell, we have not had a specific requirement to be able to capture things like functional status and we felt it was important to add that.

Neil Calman –The Institute for Family Health – President and Cofounder

Yeah, I think it is.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

And I think it would be good to add what Neil just described too, which we could functional disabilities, and that could be treated as a demographic characteristic.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So, why don't we put that comment under demographics, because we did talk about that when we addressed it.

Eva Powell – National Partnership for Women and Families

Yeah, and this is Eva. What Neil has said is true, and we are actually working with folks in the disability community to help identify a list, as well as standards to go along with that.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So Michelle, could we put that on the list if it isn't already. I think it is actually on our list for Standards Committee.

Michelle Nelson - Office of the National Coordinator

Yup.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay. So then…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I think if we ask…this is Charlene; we ask the Standards Committee, I mean, certainly activities of daily living and those kinds of things, but there are standards for…scales for depression and falls and all those kind of things. So, anything that they can identify that are potential emerging standards, in some of these spaces, might be helpful.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is Leslie, and this is also an opportunity area in the future for patient generated data.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

The next one is preferences for patient engagement. And I'm trying to remember exactly what we meant here. So, there's some preferences around how the patient wants to be contacted, but that, I think, is already included.

Michelle Nelson - Office of the National Coordinator

Yeah, so that's what this meant David, it was identification of the patient's preference for how they wanted to be engaged.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So communication and then making sure…this is Leslie…going along the lines of other requirements. So, for instance, in view, download and transmit, we also will have the ability for the patient to say, I want that automatically sent to me, or automatically sent to someone else. So, perhaps we were talking about this for communication preferences initially, but understand that that will grow broader as we move forward in meaningful use.

George Hripcsak – Columbia University

So we put forward an objective, right, and then…in group 2, and then that didn't get accepted, am I remembering correctly, and so we just need to put that back up again. Isn't that what happened? I have to go back and check…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I think we re-recommended it as part of our input for Stage 2.

Michelle Nelson - Office of the National Coordinator

Right, we just need to see what happens with Stage 2. And so this really is a deferral from subgroup one to subgroup 2 essentially, because this was part of the subgroup 2 conversation. We just didn't want it to get lost.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, but I think it's there, right? I think it is in subgroup 2.

Michelle Nelson - Office of the National Coordinator

Yes.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so we can take this off of group 1.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay. And then, the next one could either be in this subgroup or in the care coordination subgroup, but let me tell you what the point was here. The point is really to be able to close the loop, so, when there's a transition, you want to know that what you sent was received, you know, when a patient is referred, you want to know if they showed up, and we haven't had a mechanism to sort that out. So that's…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

David, this is Charlene. On that one, we've got kind of the close the loop element, but what we needed was something that…we talked about it and certainly got that feedback, that we need this concept of an e-transition order and an e-referral basically, so that when one of those cases occur, one of those use cases occur, it can be communicated and you can kind of have a status and then you kind of know did it happen or not, you could follow it up. And then there's the…and we have in ours then, the ability to feedback that status to say, "yup, got it," closed, or something like that. So, we closed the loop in our requirement, but we didn't have a means to send out, if you will, the order. So, the question is, does this…we can put both categories under transitions of care, but since you had identified referrals, we just kind of closed the loop from the other perspective, assuming there's an order status or something that we could update.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So, I guess there are two ways to handle this. One is to build a special sub-part of the CPOE orders and describe this referral order that has various steps; you order something, it is received and it is fulfilled, i.e. the patient is seen.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

And we could either classify that as a special order or as part of the close the loop in care coordination. Sounds like the order might be the better category.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I think so, personally.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Do you want to just bake these concepts into the CPOE objective?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah, that would be good.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And so we kind of were thinking like, just like you have e-Prescribing, it's similar in flavor, we start to move in that direction.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay. And then the next one is that the record should have the ability to accept a variety of data types from devices, using limited specific standards. Here we're thinking about being able to accept data from glucometers or scales or that sort of thing.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Now, we did cover that in category 2, right?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

May have, and if you did, then that's fine.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

But you know Paul, those are kind of…some of those fall under…the question is, some of those fall under lab results, so does that…because we have that requirement in there, so does it just…means to capture lab results then?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

This is a little different than lab results.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

In some cases, but…

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

It's generally…it could be a very different standard being used, than LOINC generally falls under more of a telemetry or biomedical type of an interface.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

That's covered under continua, yes.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yeah.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Still the content of that standard, we don't care about that, but we care that it's LOINC'd, if you will.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah. Michelle, do you have that handy in terms…I think that's covered in category 2, right.

Michelle Nelson - Office of the National Coordinator

I'm checking. I believe it is, but I have to verify.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

And then if not, we'd send that over, in terms of standards for interfacing to home devices.

Michelle Nelson - Office of the National Coordinator

Yup.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

That's fine.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, great.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

This is Charlene. If we can keep the domain space the same, if it's lab data or vital signs or that kind of stuff, such that…because those standards know source, right? But if the content can be consistent, that's really important.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, it has to be…it needs to accommodate those, so, the glucometer readings from home is a different glucose reading than that done in the lab, etcetera. But, you're right…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, and it's more specifically a different LOINC, right, wouldn't you say?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

No.

Charlene Underwood – Siemens Medical – director, Government & Industry Affairs

It's the same LOINC code, because sometimes they are specific by the means that it's captured.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

It could say source, so it's the same…might say glucose meter reading of, but source, home device, type, a particular type of device, so that the range may be more finite or not as specific. So, there is a combination we could get more information about that. But I think the goal is, we want a two-fer, every time we do a standard for use inside of an eligible provider or a hospital, it should also accommodate the home equivalent.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

As long as it's clear, but I'm sure it is. Yeah.

(Indiscernible)

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Go back, so Michelle, let's just…

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And also accommodate a different cadence, right, so if I'm at a hospital and I have a reading that's every 15 minutes, my home reading might be gathered every 15 minutes, but the doctor only wants to see it once a month.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So Michelle, we just have to make sure we add to that, append all these issues, these questions.

Michelle Nelson - Office of the National Coordinator

Okay.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you.

Michelle Nelson - Office of the National Coordinator

Yup.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

All right, anything more on category 1.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

That's it.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

All right, thank you. So, as I mentioned, the next two calls we're going to sort of take a level up and sort of, do we have a good breadth and good depth for things that are important, that meet our priorities for how to use meaningful use in order…for healthcare. Okay, you want to move onto subgroup 3 then? Charlene.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay. All right, great…see what you have on… I'm going to set this up just a little bit because my approach, what I'd like to do for purposes of the subgroup, is kind of walk through the strategic direction of the group. And then to actually kind of maybe walk through the requirements and then come back, because I think we need to talk about our strategic direction statement a little bit, kind of in terms of sensitivity for the time. So, with that, my workgroup, I want to thank Michael Barr, Leslie, Eva, Larry Wolf has joined us to represent the long term care view and Michelle, who's been helping us out.

We've created a working document that has all our findings in and reflects the work that David did last year on care coordination. We've had help from listening sessions and we've documented the conclusions and findings in that workgroup. And we spent some time, because we thought Stage 3 is a little further out, so we started a little bit with vision and then made some recommendations, and I'll just highlight a few of the points on that before I start. Again, from a vision perspective, we recognize the emergence and importance of a collaborative care model that has shared responsibility and accountability. And we also understand that where care coordination is kind of by definition transactional, care collaboration is more holistic and dynamic; so, it will be very dependent upon this bidirectional communication. So we worked pretty hard in terms of making sure we did things like ensuring communications. We had listening sessions, which gave us the state of transition care standards, because the state of the standards was an issue in Stage 1, we heard from thought leaders and we also heard from people relative to what is the current state. And again, we heard in that conversation how important communication is, especially communication with the patient.

So, our recommendation that you see on the first slide, and again, this came through the process; while we really recognize, and to some extent are really humbled by some of the challenges to even getting data exchange to work today, and factored into the workflow. We think by Stage 3, strategically we need to begin to transition from today's venue-specific orientation in our work, to a, if you will, more collaborate or patient-centric solution approach to our work. And our rationale for this is that we believe the standards are emerging and will solidify that with validated in the testimony. From a vendor perspective, products are now emerging and will evolve and improve, I think, as the standards solidify. And we also see this as a fundamental step to really support the recent Supreme Court decision in the direction to implement the affordable care act.

So, with that being said, what this document contains is kind of the strategic direction statement, and this actually came, Paul, if you will, as you were asking us about how do we start to move to this concept of this electronic whiteboard and this shared view of care across all these collaborators. And it came from our conversation about, and actually, as we were talking about care plan, how do we move to this more collaborative care approach and we kind of talked about it in terms of a platform. We don't want to presume the vendor has to develop a separate platform, it could be part of their products, so we're trying to keep that open and not prescriptive, but you'll kind of see that word in here. So, in our first kind of statement, and this could kind of be our strategic direction; what we recommended was, to meet Meaningful Use Stage 2, eligible hospitals as well as professionals should be able to implement a solution, and this could be modular, that, and you'll see it here, tracks individual care goals, records care team members, their roles and contact information, tracks task and steps, feeds population health management.

And again, this is an important piece to understand what's happening with that patient and that population…facilitates the reconciliation of medications, problem lists, goals and the plan of care, and then allows for input and viewing by the care member, patients and their caregivers. And this includes the functional status information that we discussed. And there's a couple of proposed measures, and we hadn't decided on the should this be menu, should this be core; but, basically that this capability exists for 10-20% of the patients and that those people who are recipients in the care transition, can access their information from this collaborative care plan. So, the reason I put this first was as I go through some of the detailed objectives, you'll see that we positioned them from, if you will, a hospital EHR perspective or an ambulatory EHR perspective and this starts to strategically starts to integrate this into a more holistic view, and if we follow this direction, then maybe some of those specific objectives could be subsumed. It's just that we're at that tension between what's happening today within a venue specific view and what's happening today as we try to move to this, if you will, patient-centric view.

So, what I was going to do next is kind of walk through the specific objectives that we have, for instance in each of the elements, medication reconciliation, problem list reconciliation. So we've got those identified below the referral piece, but before I go there, do you want me to stop and kind of just take input or would it be better if I just walked through the remainder and then we come back to this point. Because this is really where we kind of need some guidance.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So, I wanted to take a pause here, one to congratulate you on this is the kind of preamble that we'd like for the entire Meaningful Use Stage 3 recommendations. In a sense, as you point out, is sort of a vision and a strategy for how does Stage 3 address the new world, the new care delivery model, the new health model. And I think you did a really lovely job, both in your preamble that you spoke, but also you captured it in some of these components that contribute to that, to creating that new model, in what you wrote here. So, that's the kind of thing we want to do when we take a step back. So, if staff can sort of look at that transcript…that kind of thing, I think we want to put right up in front for our Stage 3 recommendations when we produce that document for the Committee. Thanks Charlene; that was great. Other comments about…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I did write it down staff, so I can send you my notes.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Great.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

…the preamble, the other's set up.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Other comments about that, does that make sense, as I think it really fits this particular section well, but it also speaks to what we're trying to do with meaningful use in general.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Paul, this is Leslie. I think that because we are so far out ahead of meaningful use 3, compared to the others, I think it's so important that we talk about the what we want and then the how do we set up a process and a framework for that evolving technology and standard. And I think Charlene's done a great job of outlining that what or that vision.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, let's get through the individual items then.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay. So again, now just to frame…the individual items are kind of in our old context and we did not have time to kind of go…we wanted the input of this group in terms of how we frame it. So, med reconciliation piece again, we felt we needed more information to determine whether we should increase the threshold higher; right now, I think the meaningful use workgroup recommended still 50%, we recommend it is a complex process. Clearly, it was recommended to go to 65%, so we were kind of holding on that. The question that we would like some input on here is that from the vendor community side, there's quite a bit of work now happening relative to medication allergy and intolerance reconciliation and a lot of discussion about that, that's required in certification. And, we felt that it was important to either add that in or create a separate component here. And again, the reason allergy reconciliation is to some extent challenging is because in some cases you'll say you're allergic to a generic name or brand, but it's to the ingredient that you're allergic to and then you've got to know that and you're figuring it out really what you're allergic to, so, it's a little complex.

The other component that we thought was, could we start to fill in in this space potentially some patient generated data; whether it's that list that patient has on their PHR and/or their adherence information, recognizing that today it's kind of hard to get adherence information, but we could start to potentially automate a little bit more of that process. So, that was kind of our question on this one was, should we add in the allergy and intolerance reconciliation process as part of this.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I think we have two topics here. Let me go to the second one first, which is the patient generated data, looking at adherence. That, in theory, could be lumped under reconciliation, that wasn't in the paper world, it's not as easy, but electronic, I think you're taking advantage of that to say med reconciliation's not only what people think they're on but what they are actually on, and that in totality is reconciling what the active meds list is.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yup. And I mean, that's the process that happens today and it's on paper or in a paper bag or whatever.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Comments on that component, which is to add the adherence section information.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

Eva Powell – National Partnership for Women and Families

This is Eva and this is a little bit of a picky point, but it may be good to term this something other than adherence, because even though there is certainly an adherence component that kind of insinuates that it's something that's already been prescribed. Patients take a lot of things that are not prescribed, either over the counter or…I think it is more empowering for patients to call it something other than adherence, because it may be a choice of their own.

George Hripcsak – Columbia University

There are two concepts, as you said, even within this one; it's what drugs should be on the list that all the doctors seem to be missing; it might include over the counter. And the second is, of the drugs that the healthcare providers think I'm taking, which ones am I actually taking, and which ones and where the patient's going to enter that I don't know, but those are two different things.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, and you've also pointed out, and what are the ones that nobody actually suggested that the patient is also taking, but they're all important…

George Hripcsak – Columbia University

But that was what I meant by over the counter, I mean, presumably, it's over the counter, if they're getting the drug.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Other comments about this? So, I think it's adding an additional element to traditional med rec.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, we can add in, okay.

Amy Zimmerman – Rhode Island Department of Health & Human Services

And, this is Amy, I'm sorry I had to leave for a minute. Are you talking about including it in this one or making it a separate; I know you still have that question down there.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I think it's including, right? We're basically…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I would include the patient generated element in this, add that. The question was - the allergy intolerance, should that be the same or separate, was the question on that one?

(Many people talking over each other)

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

…separate. I mean typically, I personally think it should be separate; I think it will get too confusing trying to put it all in one.

Michael Barr – American College of Physicians

Hi, this is Michael Barr. I'm thinking they all should be separate.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So Michael, you would want the patient piece separate too.

Michael Barr – American College of Physicians

I think we're bringing a completely different concept with the patient generated component, and, I think it should be called out separately.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I think it should be called out separately, but I think this is…we are trying to bring a different component into the broad med reconciliation activity. We were only limited because we, one didn't ask and two didn't have as much information about what the patients really taking.

Michael Barr – American College of Physicians

Paul, maybe I'm thinking a little bit further, where there may be other patient generated data components that we want to add, and this could be one of a set that might fall in a couple of different policy priorities.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I mean, that's true, but what we're trying to do is help the workflow. Right now, thinking workflow, the physician is trying to figure out what chemicals are going in this person's body, that's when you'd want to consider all sources.

Michael Barr – American College of Physicians

Yeah, I'm not questioning that at all, I'm just saying as far as a new type of objective, this is kind of different than everything else so far. That's the only…so making it a separate one that needs appropriate attention, and I think it could get buried and lost in here…adherence information, patient generated data and adherence information, which are both two very new concepts, embedded in a larger one about medication reconciliation, at least gets me a little concerned. I agree with the concept, I don't know how it's going to get done, but I agree with it in concept.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And Michael, this is Leslie. And it's something we talked about also in the patient engagement team because we said there's going to be patient engagement issues throughout the entire document; do we call those out as separate engagement opportunities, or do we just simply say that we're adding the patient engagement component to…as a logical outgrowth, of an existing policy. So, this is a logical outgrowth…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

That it's logical outgrowth…

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

…ciliation. And so that was a bit of our thinking. Where it is a logical outgrowth, add it there, where it is a completely new concept, that doesn't have anything prior, then that becomes another issue.

Michael Barr – American College of Physicians

That's exactly the issue Leslie, and I'm coming on the side of lumping all the patient engagement stuff together and not diffusing it through the different elements, in different places.

Eva Powell – National Partnership for Women and Families

Yeah, this is Eva. I have to disagree with that approach because I think part of what we're trying to do, and this goes back to Charlene's earlier piece that we just decided is really part of the overall strategy for meaningful use is to really focus on team-based care and a collaborative care model. And the minute you parcel patients out, you've made them secondary and I think that's the polar opposite of what we're trying to do. And I agree with Michael that this is a very new idea and concept, but it's a very necessary one, one that's long overdue and to parcel it out makes it less important.

Michael Barr – American College of Physicians

Well so…

George Hripcsak – Columbia University

Guys, hold on - wait, Michael, stop. We have 20 minutes left to cover all of patient engagement before we start group 3. So, I think how we organize it, we can better tell once we have the whole panel of all our recommendations, and then kind of have a more extended discussion about that.

Michael Barr – American College of Physicians

That's why I'm…

George Hripcsak – Columbia University

I would suggest, and in fact, when you break it up into a lot of objectives, you vastly increase the probability they're going to drop some of them. So I would suggest we just leave it as it is here for now, and then when we see the whole thing, see whether we need to re-organize it.

Michael Barr – American College of Physicians

That's fair; just I do need to respond to one thing. By my suggestion, no means was I moving away from a team-based concept or making patient engagement somewhat less of an important priority in contrast. The way I'm thinking about it actually elevates it in both cases. So, please don't insinuate any motive for my sentiment.

Eva Powell – National Partnership for Women and Families

No, I didn't mean to insinuate motive, I think that's the way it'll be perceived.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So, I think we are including patient generated input into the whole med rec activity.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So, that's taken care of. Now let's go to the first point, which is allergy and intolerance. We haven't talked about that, I don't believe, but as one of the outputs from the patient generated data hearing, we had a suggestion that there's this whole notion of what's an adverse reaction, can be extended beyond medication allergies and intolerance to procedures.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, contraindications.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Contraindications. So, we haven't talked about it and this would logically fall under category 1. But I wonder if there are things that physicians and other providers consider when making a choice, when making a decision; one is a true allergy, another is intolerance, because that's still a bad effect for the patient and the third has to do with procedure intolerance. So, that seems like a separate objective, almost, for category 1.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

What do people think about that?

Amy Zimmerman – Rhode Island Department of Health & Human Services

This is Amy, and that's where I was going with my comment before, because I did think in that regard, that is separate, and I was looking ahead to that question. So, I so think that is very important and I do think it needs to be called out separately.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

And does that category of contraindications, until somebody comes up with a better word, fit? And there are multiple ways, there's an allergic…a true allergy contraindication, there is an intolerance…there's an adverse side effect kind of category, and there's one about procedural…

Amy Zimmerman – Rhode Island Department of Health & Human Services

I mean I think…this is Amy again. I think it's a generic enough term that it lumps all those together and I think they all have to be looked at and be really obvious to whoever is treating the patient. And I think some are going to be…I think some may be patient generated and some may be already documented medical fact.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And Paul, this is Leslie. As long as…we think that would patient, values or direction be in this or would that be someplace else do you think?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I think someplace else. David, how does that feel to you in category 1?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I agree, and the only area that I'm a little nervous about is the procedural part of things. I'm not sure what you mean there, but…

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So, this actually came up with Nikolai, talking about complications from a central line placement, and for whatever reason, he clotted off and had a PE and then they were brought to repeat the procedure, only because it wasn't documented well in the chart, but he was having to make his argument on the OR table, on the procedure table. So, the notion of, there are things that don't…we already know don't work well in this patient, and it's just we need to find a convenient place for that to be made known to other providers.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay, I'm just nervous about lumping that with allergies.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I wouldn't be lumped, we're creating a new category called contraindications.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah, okay. Then I'm okay with it.

George Hripcsak – Columbia University

So Paul, medications are already in one and then the reconciliation of those medications is in three and similarly contraindications would be in one and reconciliation of those contraindications presumably would be here in three.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I don't…you might be reading…

George Hripcsak – Columbia University

If you want to reconcile those, or at least share them.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I think at the first stage we're just trying to get them in a noticeable place, so that's sort of a one. I mean, overall, again it goes back to Charlene's preamble, in general, we're not trying to stick them in a place only for the use of one entity or one provider, it's really everything you do, you'd like to have shared. And then there's this notion of how do you reconcile, which is a challenging issue. But I think right now we're just trying to get it in a noticeable place in the EHR. So, I think that…with that amendment to category 1, is that something you could add to category 1 then Michelle, so we'll be able to look at it when we go back to the overall.

Michelle Nelson - Office of the National Coordinator

Yup, it's added.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Great, thank you. So I think - does this finish this item, Charlene?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I'll separate the patient generated data, we'll leave for this purposes here until we come back and look at the whole and add separate objectives for medication allergies, intolerance and contraindications.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So you're not separating patient generated, its part of your reconciliation. Yeah.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, next slide. Okay, so this is a biggie, and we certainly appreciate the complexity of managing problem lists because in hospitals, if they even exist, they're venue specific, in ambulatory care they can be patient specific, there's nursing problems; problems can be acute versus chronic, resolved versus not, so there are a lot of issues around the complexity of problem management. However, it was felt that we needed to put a stake in the ground, because this is going to be essential to be able to move to ultimately care planning, because basically problems can, if you will, lead you to an appropriate care plan. So, we put a stake in the ground for Stage 3 that's this reconciliation should be occurring. And again, there's going to have to be work on the part of standards in terms of helping to sort out some of these different relationships and the coding behind them and work between now and Stage 2, to actually do this. Problem reconciliation is a requirement for certification for Stage 2 right now, so again, there'll be some experience with at least the vendor community in Stage 2 to start to reconcile some of these issues. Any comments or additional questions? And again, we put 50% for Stage 3, but again, the thresholds will have to kind of be adjusted as we go through.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

This is something we've been shooting for a lot in prior stages. Is there a way…the measure is listed as this activity has occurred for more than 50% of transitions, which is sort of a check off measure. Is there any…and I don't know how to do this, but, is there any more byproduct kind of a measure?

W

Perhaps it's a new status of problem list Paul that says you have the chronic problem list, you have the episodic problem list and then you sort of have that lifetime record of problem list. Because they are different in each care sitting, how people view a problem list. And that's why we thought, well, we sure need direction, and so one way to measure might be through do these…have they been reconciled and do they exist?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, so you could have, is your problem list reconciled status, right?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, that's what I mean by check off though. It's hard to prove that some…that an activity took place, but that's in theory, you'd like to just know that the actions of reconciliation have taken place, rather than have to force somebody to do a check off.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Well because, I mean typically, I mean how the vendors would do that is they'd add a documentation element to it.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

But, that's the…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I know, I know, but that's what we'll do.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Right, I mean the underlying thing is you want to make sure that the important things are there, but I don't know how to do that.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. Well, one of our main objectives is really to cause certification criteria that say, instead of the provider having to go from screen to screen and mentally trying to reconcile, do you have an activity where he can see it all in one screen and say, add, delete or edit and consolidate. That's the functional criteria we…and that will accomplish, just by having an objective. So that's a good thing. Can we get a measure that is…that says that you, it may be as simple as you were at this screen, without saying oh let's add yet another documentation which really doesn't hold a lot of meaning. Well, anyway, that can be homework…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

…more homework.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

…but the point is well taken. Other people's comments on the point of problem list reconciliation.

Amy Zimmerman – Rhode Island Department of Health & Human Services

This is Amy and I just have a question. Where does…where would patient input or patient generated information on the problem list occur? So, I'll give you an example. This morning I happened to be at a doctor and I looked in my own patient portal last night and saw something under the problem list that I never knew was there or that I had. And then the specialist brought it up with me and I'm like, yeah, no one's ever talked to me about that and I'm not sure that's accurate and he sort of said yeah, you're right, I don't think it belongs there. So, how does patient reconciliation on potential problem lists come into play?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is Leslie and I think that also gets back to a collaborative care record where you have multiple parties participating in reconciling that, whether that's the patient and their family member or the provider, this whole idea of adding members to the team, then reconcile multiple input, then distribute multiple results, is really what we've started to struggle with saying, are we creating the right steps to get to that collaborative care model.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Right. I think it would be worth having a special one around generated stuff. We've looked at this a lot and patients are willing to generate problems, the provider's problem lists are really incomplete, but then the providers don't do anything with them. So, requiring them to do a little reconciliation around patient generated things, I think, will be a big positive step.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So include the patient…for purposes of our direction now, we would include the patient generated component here.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

Michael Barr – American College of Physicians

This is Michael Barr; can I just weigh in real quick here? I'm probably going to create some more comments. I think the problem list for physicians is very different and treated and I also…I was very supportive, as I was before, about patient generated data becoming part of it but, that changes the definition for every physician about what the problem list is. So, I just want to make sure we recognize what we're doing by suggesting this here, and anticipate that it's not going to be well received. There should be patient generated data and patient generated things, and the physician should take those into account, modify what the traditional problem list is.

(Indiscernible).

W

Mike, don't you think that's also the case trying to reconcile the problem list between the inpatient setting, primary care and the specialist.

George Hripcsak – Columbia University

Now you see, there are two different problems. You don't want to reconcile inpatient and outpatient; I think those are just two different problem lists. There's a problem list, which is the…say a physician's, for example, work list of what I need to do; the potassium is high inpatient side, I need to address that. It's iatrogenic, so it's not something the patient needs to remember long term, just something they need to fix right now and will eventually come off the list. Then there's the patients longitudinal problem list, which is the thing that the patients participating in, it's not just the doctor's work list. So, I think what Michael's reacting to is it's kind of like there's two different problem lists.

Michael Barr – American College of Physicians

Well I mean, I think they need to be…a clinician on the healthcare team needs to be looking at all the problems that are generated both by the health professions and the patient's families and so on. But, the definition of a problem list that every physician has been trained on is the list of things that I'm tracking for this patient or have gleaned from a hospital discharge summary or so on. And I think by saying now we're going to start inserting patient generated information to that list, we're changing that list dramatically for every health care professional. I'm not saying we shouldn't have patient generated information in the medical record, I'm just saying by what I thought I heard people suggesting, we'd be dramatically changing everything that physicians have been taught.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I don't agree with that Michael. I think people, physicians, would…well, some physicians would appreciate the updates, additions, and corrections on the problem list. They certainly can all be annotated with where they came from, and I think that's just sort of a general rule we want for all these exchanges. But, I don't agree with your statement that physicians wouldn't like this.

Neil Calman –The Institute for Family Health – President and Cofounder

This is Neil. Sorry. I was just going to say, you know, I can see both sides of this. I mean I think the problem list is really a physician tool, it's a way different people organize their thinking about the management of a patient, and even between providers, they use problem lists differently in their practice. I mean, it really is a tool that physicians use to organize their thinking and manage their practice, and they sort the problems in particular ways, you know, people put the most important things that they want to remember on the next visit first, and they do…it's a tool that they use. So, I think giving patients input to that tool changes the tool completely. And I think having the ability for a patient to say, I've noticed on my problem list, it says that I had gallbladder disease and nobody's ever mentioned that and I think it must be wrong, and messaging a provider or something like that I think is appropriate. But I could just see a patient put…sitting down and putting on their problem list, I have headaches once a month, occasional knee pain when I wake up in the morning, and just building out a list of like 18 things, almost like the list that somebody would bring to your office, for a visit. And I just think it is a provider tool. On the other hand, I do think that it's important to get patient input, but we should figure out a different way to do it.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

We just did a study looking at how patients respond to seeing the provider's problem list, through the personal health record, and it's, I think the biggest study like this. Patients really liked it. There were some things that…there were a few things that created worry, that they got upset about, but on par, they found it to be enormously useful, they actually went and did a lot of internet searches. It was really a positive thing, although in some instances there were a few things that they reacted to, there was much less of that than I actually expected.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, maybe I can clarify this…I think it's the elephant problem. We're looking at different…we're looking and hearing different things. So I think what…this is to say, patients have, one, access, but two, input. But it doesn't mean that they can add anything they want, at least without…it could be in a different section, for example. But, it goes through the same reconciliation process where a physician, or whoever's list this is, can add or edit or delete from their list that's helping them manage this patient, but we're incorporating patient input. Does that make it sound any better Michael?

Amy Zimmerman – Rhode Island Department of Health & Human Services

This is Amy and that's kind of, what I had in mind, and I'm wondering if we're getting tripped up in semantics between diagnosis and problem list. And I'm not quite sure how EHRs and PHRs define them. I mean, when I looked in my record yesterday, I'm pretty sure it was under problem list but it was a diagnosis.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yup, yup. And often that's how they work today.

Amy Zimmerman – Rhode Island Department of Health & Human Services

So I think that's partially where, I didn't necessarily mean reconciling that I did or didn't complain of headaches or something. I mean, everything on my problem list was some sort of documented diagnosis except this one I didn't know I had and I didn't…and of course, I like everyone else you researched, went on last night and Googled it to find out what it was and then had a discussion today with a specialist saying, does this apply or not, I've never heard of this.

Michael Barr – American College of Physicians

So this is Michael, that's exactly the kind of conversations we want to stimulate. The only thing I'm reacting to is what Neil was alluding to, did a much better job than I did in describing; what I foresee could be a problem, where physicians who are used to generating the list in their language. Obviously this is going to be more standardized as we go forward, that they have organized and things they believe they want to track, I'm just concerned that if it's…not that you Leslie wouldn't be able to see that list and contribute to it, but if you had narrative you wanted to add about your problems, I just hope we're not suggesting that that becomes part of the list, because that's…it should be filtered, put in the language that the physician is going to respond to best, because that's what they're going to look at first. And they should also have patient generated data in the electronic health record which could be a narrative list of problems, and could be part of the discussions, hey, you have something on your list I haven't really categorized on my list; let's get that done. That is the kind of conversations I think are absolutely important. But I think changing the fundamental way physicians deal with medical problems, diagnoses on a problem list, is something we shouldn't take on very nonchalantly; I think we really need to consider the impact.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

This is Leslie and I agree it shouldn't be nonchalant and I think that's why Charlene did the preamble, because this is a change; however, isn't it better to know? Don't we want to have the same play card and problem list is one of the very first elements. And I think you described two issues. One is the problem list, the list of things that is harmonized across care, that is patient centered, which includes patient generated data. But then there's also a patient observation, it might be…that you described Michael, that's a little bit…that's much more detailed. So we want to adhere to the same structure for input, whether it's a problem list or a patient observation or a patient-generated result or patient family history; there's a lot of different components and we want to be mindful of that. But this is one of the first steps, like do not pass go; we have to have a way to harmonize the patient as a team member and the patient as a contributing member for the problem list.

Michael Barr – American College of Physicians

Once again, we're not disagreeing on the fundamental goals, but I am concerned. Again, representing a membership organization of physicians, and thinking beyond them, that this is going to be a fundamental change in the way they document in their chart, and we shouldn't take it lightly. I absolutely agree that all that…everything you described should happen, short of…offering a generic opinion on the basis of what I've talked to physicians about, changing the way they document their clinical record, and medical legal…I mean, this particular problem list, the way I'm defining a problem list, there's medical legal implications, there's review implications, there are lots of challenges and I just foresee a lot of push-back if we push it in here. I don't think it'll be as much if there is sort of a patient or a shared section that we don't call the problem list, where there's a narrative that's combined, that becomes part of the clinical record.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so Michael, you're…I think you're a part of this subgroup, right.

Michael Barr – American College of Physicians

Yes.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes. So we'll take this back….

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So may I suggest Charlene that, I think we're in agreement that we need this activity of reconciling problem lists, I think we're in agreement that we need…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And it's a big list. We…this is a big list and that's why we wanted to…

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So could you just go into more detail and sort of answer some of these questions, and they may not be…and think of it as stages. So, what's the first new…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, stages…

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

…yeah. And so bring back a finer grain description so that we can present this at the full committee and not have to deal with all these issues all at once.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, okay. So again…what Leslie said, we think this is one of the strategic elements and we know it's a big list for all the discussion that we had. And we will break it down.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Great, thank you. Good topic though.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Next slide. I know we're…I don't know if Art's on yet. Okay, so, this was the situation where…okay, this is the current state where there's a summary of care record for 50% of transitions and recognizing this has been certainly a challenge, to accomplish in Stage 1. So again, as we move to Stage 2, we actually kind of broke it into two pieces and again, depending on what happens in Stage 2, maybe one of the objectives could change or become part of the collaborative care summary. So the requirement was again, similarly, the use case of transitions either to another care setting and/or referrals to another provider; we go confirmation that providing the care summary record is important and we agreed that that should be sent. And this is where we identified that need for this concise narrative of support of care transitions, explaining the course of care and the changes in the care plan. Again, kind of that physician, what they're kind of taught, what we're hearing, that summary and do that immediately and then provide an update for supplemental information. So, we ask in Stage 2 that we move to immediate availability.

The other piece of that then is that the recipient is actually able to receive a core set of this data, and I just kind of didn't limit it to the concise narrative. And our measure, on the next slide, I want to talk to that too, because our measure was actually…can you move it up a little, next page, thank you…was that we talked about this, that we expect that this is going to…we've had feedback that well, could it be an alert, could it be the full document, specialists want it at a different time. We assume that once it's available, the system's smart enough to kind of know that it gets it and actually could manage whether a physician wants an alert or a full report, da, da, da, da, da. So what we're looking for is a documentation acknowledgement of the receipt, from the recipient provider for 20% of the patients who are transitioned. So we're trying to close the loop as we move into this stage. And again, it's that feedback piece. So, that's kind of how we made modifications to this one.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so the first piece is to have an immediate concise narrative when a transition is about to happen.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Or whatever data is available, like…so you've got your CDA, whatever data's available, that just happens, including this narrative.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And, but…this is Leslie, but using the same framework that we have today where you might get a partial lab result and then a completed result automatically at a future date. We're just suggesting that what's available gets sent immediately.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, that was the…

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So the delta is the immediate, is that correct? It's the immediate plus concise summary.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Yes.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so we're going to investigate whether concise summaries are, in fact, already a requirement…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

It might be, right.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

…and so that's no new, the delta's just an immediate in electronic form.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yup.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, comments on that? No comments, does that mean acceptance?

Arthur Davidson – Denver Public Health Department – Director

Well, this is Art and I think that you'll see that we're kind of talking about the same thing in public health.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Amy Zimmerman – Rhode Island Department of Health & Human Services

This is Amy and I had one question. I realize we're thinking 3-1/2 years out, but if some of these transitions happen to things like long term care facilities or places where they can't actually…they don't have an electronic system to receive it…

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Right now, it's not electronic.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Oh, it doesn't…okay, thank you. Okay, you just answered my question.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. So the next piece you're introducing is that you get a receipt…an acknowledgement that this was received for 20%. Is that it?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes, yup. And recognizing today, one of the certification requirements is that the rest of the CDA can be imported, there's a lot of push-back to that, but by Stage 3, we thought we should be in a position to…you know, we'll know more.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

But now some of the recipients are not going to be meaningful use covered entities, so, this does fall in the category of how do they control…how does the MU EP or hospital control the availability of electronic receipt actions.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And again, our assumption was that Stage 2 will be very robust in data exchange work, so that 20% should be reasonable by Stage 3.

Eva Powell – National Partnership for Women and Families

This is Eva and I think also our assumption is that the work that's going on in non-MU settings, such as nursing homes and home health, is not stagnant, that's moving forward as well. And so this is a call for us to ensure that we're collaborating with those settings to make sure that the capacity is there, because in my discussions with long-term care, they are actually, some of them, more advanced than physician practices without incentive money. So, I don't think it is right to assume that they will remain laggers, because they're not right now.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And in addition, many long-term post-acute care facilities are actually in the next hallway inside a hospital.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So we can vary certainly, what the threshold is, but the real intent was to actually bring back the receipt and the use of it.

Amy Zimmerman – Rhode Island Department of Health & Human Services

This is Amy and I think that the receipt and the use is great. And I think maybe just tweaking the percentage based on where we are a little closer out to the time, because you're right, we are 3 years out and long-term care and home health are moving in that direction; but I think it's hard to tell how far they'll get. I know in our state, since we have a state mandated continuity of care form, we're struggling now with how to align state mandates in a paper form with where the hospitals are electronically, trying to reconcile them not having to do paper, but long term care not being able to receive electronic and long term care generating paper going to hospitals that want electronic. So, I think there's a lot here but I think if the threshold is appropriately set…so I'm fine with the way it is now and I think then we just have to be open-minded about adjusting where that threshold is. But I think pushing the products to go there makes sense, and hopefully then, if there's enough lead time, the long term care and home health type targeted products would be able to include this as well.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Would you accept 10% as just being a little less scary?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, we're open…we're trying to get the capability in; you understand what we're doing.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah. Now, the other thing is, we moved this whole referral…hmmm

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I've got it next.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Let me go, and then you can comment, do I…should I combine them or not. So…

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So, other people's comments about…this isn't exactly measuring your objectives. Your measure doesn't exactly measure your objectives in one…it's really one, right, the immediate electronic availability of this transition document. Well, I guess it's related.

Amy Zimmerman – Rhode Island Department of Health & Human Services

It could, this is Amy again. It could…track it…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I can quantify that, if you want and follow that through, I can add that.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So, number two really isn't anything…what does it say? Can receive, review and…why is that part of the objective?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Here's the rationale. We didn't state the need at the receiving end for that system to import the data, that's what this states, and we don't know what that looks like and how that…what's the best process around that. So the vendors are really struggling with that, so that was why I wanted to close the loop.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

But how does that…see, how does that impact the EP qualifying from MU? How does…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

That's…it's just they receive an acknowledgement that it's actually received, and you would think to complete communication, they're accountable to make sure their communication is received, right?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

No, no…well, how can you be accountable that somebody else can receive and review…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

No, no, no, people are accountable for reducing readmissions, too, so, things that are moving a little outside of their control, so…

Amy Zimmerman – Rhode Island Department of Health & Human Services

I took this to mean, correct me if I'm wrong…this is Amy. I took this one to mean that the receiving provider can consume whatever is being sent to them on this summary of care document and integrate it into their record…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

…in some form…

Amy Zimmerman – Rhode Island Department of Health & Human Services

…form which would then help promote continuity of care and coordination overall because it will be consumed and put into proper places of their records for future use.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so the only…I guess I'm misreading it because you actually mean this provider, the EP qualifying, the MU qualifying provider can receive, not the recipients.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Well actually, I meant the recipient, but also that particular case, so do I need to phrase it…

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, I think you just mean…because a provider can't be accountable for somebody else having the system that can consume this document.

Eva Powell – National Partnership for Women and Families

Yeah, this is Eva. I think that the nuance way to talk about this is not…obviously they would have to have the capability, but the intent of the measure, in terms of meeting the objective, and this actually is something that we should probably flag for standards, is that the sending provider ensure that the receiving provider did actually receive the information. And that's a little different than having the capacity, which obviously they can't be accountable for. But they can definitely be accountable for ensuring that it was received and viewed, and I think that's the difference in care coordination, is that when you send a patient from the hospital to a nursing home, the minute they walk out the door, you wash your hands of them. Then you have further responsibility to make sure that that person got there and that the receiving facility had all the information they need.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so can you edit the measure then to say…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

…that documentation acknowledgement doesn't have to be electronic.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

But don't we want it to be Paul? We're not…

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, we do, but what Eva just said is, you just want to make sure you close the loop, that's the goal here.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Right.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

It is. I'm wondering though if the threshold being low would cover us to require it to be electronic? Because I think Amy's point about trying to deal with some nursing homes who don't have electronic and sending stuff in paper, it sounds like that's a…I could see that being a very real issue, so if we start out with those that we know have the electronic capacity…

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. Anyway, so you've heard the questions, if you can tighten this up a little bit, that would be great.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, we'll tighten it up. Okay, but you see the intent. Next page, and I know we're over…I know, so…maybe…this is the other side of the closed-loop referral. We did not include in that, because we got a request for actually being able to place orders for transitions of care; in both cases I order it, so, we can have that broader conversation. So, this was, actually we went a little farther, but the capability to track, that when you sent that order out, you could track it's status and see if you ever got something back, and maybe remind a patient, and incorporate whatever happened to come back. It could be patient…it could be a link to an image, a report, it could be the patient was seen. And then the measure would actually be the receipt of the referral completion, whatever that was, for 10% of the patients. So, we're trying to…we recognize that the whole e-Referral concept is growing in the marketplace, as we're getting to more and more…even patients could perhaps self-refer. So what we want to do is support that. There are some standards out there that support this process today and we wanted to make sure that loop was closed, because this is a problem, you know, making sure referrals are done in a timely manner.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Any comments on this? It seems like you could combine it, right, with the one above, if you just wrote it a little differently.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I might be able to, yeah, we didn't…here was the…we did hear that both of…it could be potentially a separate transaction because it's an order status, that's the way we broke it out, but in addition, they want to get the summary content with it, right?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. We just…we did…we just did add a special order type to CPOE…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yup.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

…could this…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So I'm tracking the back end of it here.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, so…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Look, we can discuss can we add it with above, okay. The more we can do that to keep fewer objectives, I'm aligned with that important concept I didn't want to lose.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Next slide. Okay, so, you can start to see where this started to move us to that collaborative platform. So anyway, we did…this was a piece that the care team members are included in the information in the care record summary, what we felt was important that needs to be added for communication purposes, is information about who the care team members are, their name, role and contact information; so that you can communicate to them, and when they're available. So to actually facilitate communication we need that information. So we have a pretty low threshold here, but to be able to facilitate this we need…and this is pretty complex to do too, because people are on call, and they have delegates and all that kind of thing. But this is important for communication.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Now, what is the extent of health care team members? In Stage 2, we recommended a minimum of PCP.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

We actually were all members of the care team at this point in time is what I think our statement was.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I'm not sure anybody knows that, right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

I know, I know, I know.

Eva Powell – National Partnership for Women and Families

This is Eva. This is intended to be cross-settings as well as part of the collaborative care platform. So the idea is that whoever has a role in the care plan would either add themselves, the patient could add them. I think we can do some homework to refine the recommendation there, but it's definitely intended to be all encompassing.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And, this is Leslie, to understand that this might be fluid and changing, so we have to accommodate that ongoing movement and change.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So just a comment that I was going to make towards the end, but we had as one of our principles, it can be aspirational, but it's got to be achievable and then in some total, we can't totally overwhelm the system. I think one of the things this particular subgroup needs to go through is look at that and just…you can't move the system that fast that far all at once, especially when we don't know…like I said, no human being probably knows the care team members, including any of the parties or any of the patients together, so we can't ask them to do something that no one can do.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Paul, this would be one that would be potentially deleted if we use the one that I put on the top as the objective, which is kind of like this future state. So, we could potentially delete this one. So…

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

When you say up top…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

The one that I started with which said, if we would actually collapse this objective…I said the first objective, which was have this collaborative platform in use for 10% of the patients, that includes...it has this kind of information in, then…because that's where that information about some of this contact information would be stored. So if we collapse…this one would actually go away, in my view, if we use that broader objective for Stage 3.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, I understand that yes, this would be included in that broader whiteboard, but, you still need the specifics and when the…you need to find an objective that would use specific and achievable. So in fact, like our Stage 2 recommendation as far as starting a list, having a place to hold the care team list and starting with, well at least the PCP where that exists, it's achievable.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay, so we'll…

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Just be more precise and then really do take a look at your whole set of objectives and measures and see what you can do to try to get towards something instead of getting all the way there all at once.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yup, same thing with problems, right?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, yeah. Okay, next?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Next.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Anybody else disagree with that or have other overarching comments?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

This is actually what led us to that recommendation that we started with, because we started to talk about...we recognized that care plans and EHR are pretty complex because there's problems and there's interventions and there are multi…one points to another and they can be…and they're specific to a care setting, to what the problem your resolving is there, that type of thing. So again, this was…we're trying to put forth the capability to mediate a care plan from one provider to another, and we do recognize, for instance, the work that's being done by the Standards Committee that there is a progression that's being laid out in the standards to be able to get there. So, we had…there's two dimensions to the capability, and I'm going to just cover one and just get feedback right now, because the next one we start to…it even goes a little further. That's this capability to receive and review a care plan supplied by another provider and the ability to even incorporate a narrative history, so that they could look at it. So, we tried to start simple and likewise, the capability to transmit that care plan, and it could be narrative, when the patient's referred.

We're not stating whether…we had a discussion could it be a document in itself or is it part of the CDA; we're going to leave that to standards. And then, what we had as a measure then was documentation of the receipt. Again, we got a little bit fuzzy here, review of the patient care plan for 30% of the patients who were transitioned during the reporting period. So again, this could again be…if we would go to the higher level objective of the collaborative platform, that would be the means to be able to do this, because this is pretty complex stuff we're dealing with. So, that's kind of, where we…as we had this conversation was where emerges a need for this more patient-centric capability.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

People's comments on this.

Amy Zimmerman – Rhode Island Department of Health & Human Services

This is Amy. Wouldn't this summary of care document and objectives include the plan of care? I mean, don't we want to link those together?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

And it could, it could, but…and certainly if it's a narrative it could do that.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

But we heard testimony from Larry Garber, this is Leslie, about the potential use of a consolidated CDA and also as a framework to grow beyond this summary of care document to include care planning themes. So, there's a lot of momentum here, we just need to really bring it all together.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Well that's my point, I think that…I mean, to me, this is sort of…or maybe it was just a false assumption, that in a summary of care you're going to talk about sort of what happened and what the care going forward is, and that's the care plan. So I see them as intimately linked and sort of becoming one. That's just personally, I mean, I think in any summary of care document, you're going to get what the plan was anyway, whether you call it a discharge instructions, that sort of folds into the care plan, unless you're saying, the care plan is more longitudinal over time. But to me, to separate them just kind of seems like it's more separate…the potential for more separate documents, which can cause less collaboration.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So my question would be, if we…they can…is there a need…I mean, this is kind of where we're starting to carve out some of those elements for reconciliation. What I would do on the previous one is make sure this is one of the core elements, right, that can be imported. But, is it reconciliation here or is there anything I should be doing in addition, because I'm supportive of that approach, we merge this one. Thoughts on that?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I think you may have to define even care plan. We in Stage 2 recommendation, we talked about it as goals in patient instructions. What's included in…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

We'll break it down into some additional stages then.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, and with some precision, so people know what it is, is there a standard and is there a way to consume that and make it available? Other people's comments on this whole general area? Okay.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So the direction would be to look at including the referral piece and this piece under the summary of care element.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Well see, in some sense, and this may be what Amy is saying, there's information that is very useful to receiving someone in transition of care. And can't you describe, delineate what those pieces of information are, and get it packaged up so it can be transmitted and received electronically. Because I think there are a lot of concepts, none of which are necessarily well defined, and then that just leaves…I mean vagueness is a really hard thing in terms of either certification or finding criteria for objectives. So, if we can accomplish…there's information that needs to be transmitted during a transition of care, what's the starter set and then we can build on it in our roadmap for better and better coordination over time.

Eva Powell – National Partnership for Women and Families

This is Eva. I…this is hard and I think what I'm thinking of, and I'm wondering if this is a workable solution, or at least a step towards one, is starting with the collaborative care record that we've been talking about, then using the…because part of the problem in my view is that every patient is different and different settings need different things and even the same settings need different things depending on the patient's diagnosis. So, I'm not sure that at the policy level where we're working, that we're ever going to light upon the perfect set of stuff. But, if we start with that collaborative care record, which is essentially a shared working space, where all appropriate people have access to the information they need, then what we need to do is find ways to organize that. And what we've already got built into Stage 2, assuming that it stays, is this notion of view, download and transmit, which is on the patient end. But assuming that the functionality and standards for that also apply on the provider end, then can we somehow incorporate that notion into the workflow of the shared workspace. And then say I've got a patient who's transitioning to rehab, and for rehab, I need certain information to facilitate that transition, and so, I can pick from the menu of items in the shared care record to transmit that information that is needed to the rehab facility. Whereas then when they go from the rehab facility say to the nursing home, you need maybe different information, and you do the same process, but the provider is able to pick the specific information. Is that a workable solution?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

I think that sounds like more in the direction, so, and since you're creating this container, I think you led off, you were saying, you know, it's really hard to predict for a patient or a provider type specialty, what is useful to go to the next setting. And instead of trying to be prescriptive, we'll fail if we try to be too prescriptive, what's the container that can be shipped from one system to another, that can hold the relevant pieces. Now the provider and the patient context define what's relevant in this particular transition. So, we provide the container that can go from one system to another in an understood way. That would…is that a recount of what you said Eva?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

But isn't that…well…

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Isn't that?

George Hripcsak – Columbia University

It's sounding a lot like what we recommend for Stage 2. In other words, we created the container and put those pieces in. So are what we saying, we just need to go the next step of that?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

And maybe be more precise. You are expanding the concept to this collaborative workspace, and with the vision in front, now it makes a little bit more sense both, I think, to the provider saying, oh, that's what…I could use this, and the vendor saying, what's this going to feed into next. Instead of just "summary of care documents," flowing…we're really trying to find a container that populates this collaborative white space.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, we are.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

That's the delta here, is we're describing a new thing that you can all see how you post things and consume things from this space, and now we're just making that possible. But one of our main contributions is to even describe this collaborative workspace.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Okay.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

I think you've got it exactly right Paul, this is Leslie. Because I think either we could say, hey, there's collaborative work space could be, I get a direct message, up pops a document, I edit a field and that sends an update to all care team members.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, we're making that possible instead of saying, oh, for every patient, you have to provide this and this and this…it just becomes so overwhelming. So, maybe our biggest contribution is the division and the roadmap to filling up that space.

Eva Powell – National Partnership for Women and Families

Right, and this is Eva again. Sorry, I accidentally hung myself up a second ago, but, in my…again, this is just in my mind and based on the conversations we've had over the last couple of days, it seems to me like we're moving more and more toward an increasingly modular approach to health IT and that obviously EHRs are key to that. But that the EHR itself perhaps is not the vehicle for all the information that we need, and that…and if we take that approach, it first of all enables, I think, the shared care space. But it also may aid in the adoption process, because part of what we've heard from providers is that they have to spend money on all these things that they're never going to use. And so if we can keep the basic certified EHR kind of at a minimum and then, as we move forward with meaningful use, allow for either EHR providers to add products on top of their base EHR or other companies who specialize in certain things to do that and then have the modules certified, which I think is already accommodated by the certification process; then it'll be better for everyone.

Amy Zimmerman – Rhode Island Department of Health & Human Services

So, this is Amy, and as we talk about this sort of shared care space and this whiteboard or whatever, would you see, depending on how sort of HIEs more the…are established, wouldn't you see them taking…or could you see them taking on this role, because to me there seems like, depending on the model, there's a fair bit of redundancy here.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah.

Amy Zimmerman – Rhode Island Department of Health & Human Services

I just want to put it out there, because on the Information Exchange Workgroup, they're going to look at what we're producing here and they're going to start to think about Stage 3, and it just seems like there's a nexus. I understand not everyone has HIEs in their community, etcetera, etcetera; but I'm just thinking like it seems like there's just such a natural nexus there, depending on how an HIE is established, that it could be one and the same.

Eva Powell – National Partnership for Women and Families

Oh sure, yeah, I mean…

Amy Zimmerman – Rhode Island Department of Health & Human Services

In my case, if it had these kinds of capabilities. I would hate to see shared collaborative space set up sort of independently of an HIE and have them end up being redundant and a lot of money spent in both areas, etcetera, etcetera.

Eva Powell – National Partnership for Women and Families

Right, yeah, and I know, at least in my mind, there's not an attempt to do that. I think that this opens up the world to enable whether the HIE provides these kinds of services and platforms or whether there's another vendor in areas that don't have an HIE or…I think that this creates a space where there can be more innovation and more options for providers, based on their individual needs.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Well, I just want us to keep that in…or from my perspective, I think it's important to keep that in mind as we…even with the other groups and as we think about how to bring some of these discussions together.

Eva Powell – National Partnership

Yeah, definitely.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So I wonder…we only have 15 minutes, I wonder if we can transition to talk about how we go back a little bit of a higher level to try to prune and to consolidate and to make sure we're living up to our principles, before we finish up with Stage 3 and then move into Stage 4 at the next call. Does that seem reasonable?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yes, and I just wanted to highlight again, in terms…at the end of the document, there's some recommendations for other groups, but again, I know in Da….under the quality piece, this ability to track populations, identify patients for outreach starts to sound like a registry, so that might be…so, there are just a couple…and then the last one, which is monitor that individual care plan progress, becomes the whiteboard, so that ended up in our vision, so you can kind of see how, as we worked through these, we got to the vision that we started with, or kind of that framework. So those are just there to show that we didn't…we tried to touch on most of the requirements that we heard.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. What I'd like to do is sort of throw out a straw man, and we'll put this out for…in writing, but get your reaction first…a straw man sort of criteria to help us look from a 30,000 foot level and re-look at all the things we've built from grassroots up. If you recall…so one, the intent of meaningful use is to help us have the capabilities in this tool, the electronic health record to some other HIT components, to support the new work paradigm…well, we used to call it health reform. And, it's also a floor, because you're asking the entire country to do it instead of saying, it's the max. So, we've talked about aspiration and I think what we are accumulating in all these subgroups is truly an aspirational view of the world and how do we get to the next decade's kind of tool to support patient care. We do have to worry about the achievable, and remember, this whole escalator metaphor, we do want people to be enticed to get on, because it's going to a great destination, and one that we all see in front of us and an inevitable one. We also don't want people to fall off. So, with each stage, and recognize that this is Stage 3 of many. So, there's…we anticipate there will be a Stage 4 and a Stage 5, and that we're trying to paint a roadmap and give people a line, so that they can be part of this ecosystem that freely exchanges information in support of individual's health and healthcare.

So with that in mind, and taking…I'll try to consolidate some of the principles that we had talked about a year ago, and are on the top of our pages, and think about the measure we're trying to assess ourselves against is really importance and impact of our system tools. Standards is contributing by the standards readiness, and I think that's a term that they've been using on that side, and we have to have…we have to be pitching things that are important and will be very impactful yet be feasible with both the systems and the standards that are available. That's sort of our tension and balance. And the good news is, we have time, because there's time ahead of us. So, straw man impact criteria, one is that we've always put in first is it supports the new model of care. That means, team-based, outcomes oriented, population management. A lot of what Charlene talked about in her preamble to this section.

Secondly, that is we can't tackle the entire world, there are national health priorities that are being defined by, for example, HHS, on behalf of the country. And those are aligned with, let's say the National Qualities Strategy, the Million Heart Campaign; those things were decided upon by HHS for reasons of public health. So we need to make sure that we support that, not exclusively, but it would be good if we thought of our requirements, our floor requirements, be supportive of those kinds of national health priorities. We don't set those priorities, but we need to support them. The third is because this truly…this is a regulation for the entire country, that means the entire patient base and the entire systems base, that hopefully our requirements have a broad applicability, for that various provider specialties, for the patient's needs and the areas of the country. We've talked about these things at various times; what I'm trying to now do is actually literally make sure we get these in front of us and literally bake them into our matrix. The fourth is that it's not topped out or not already driven by market forces. Since this is a reg, it's a floor, but it's a required floor, and you don't want to duplicate things that are already going on in the market. One of the reasons you don't want to duplicate it is because the market has its ways of generating and supporting innovations of solving a problem. You don't want to get in the way of that, and you don't want to work on topped out things. If people are already going in a direction, as we've always said, they're not going to turn off spigots that have been implemented, we don't have to keep chasing something because then you're destined to…the things that are legitimate exclusions.

And we've talked about mature standards that are widely adopted by, in this case, 2016. So, there have to be standards, otherwise we contribute to the silo problem, and in a sense, they have to be on their way to being widely adopted, which means that they make sense, are feasible, etcetera. And finally, the notion of subsuming where possible. So, instead of piling on, we want to either substitute an outcome measure for one where we had to rely only on process measures, or combine, so that we're getting at the proper concept, such as reconciliation. You don't want to have an objective to reconcile the meds and one on the problems and the one on the…you want the activity to be efficient for the workflow and unifying at a conceptual level, which is, we need to make sure that care…in order to make sure that care is coordinated, we have to understand the total view of a patients problems, their meds, and their preferences, for example. So, I went through those fairly quickly, and we'll put them in writing for you, but is that…does that…do those seem like reasonable organizing principles for taking a step back and looking at our totality of meaningful use objectives?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Paul, this is Leslie, I have a question. I think…could the harmonization that you spoke of first could also be not just the national priorities on health, but the national priorities on new models of care. For instance, this work really fits well within APO, and now that we know the Supreme Court's ruling, we know that those will be advanced, and be very dependent, as Amy says, on the interoperability that an HIE might provide or the care coordination that we defined in meaningful use. So, I would add that to the harmonization criteria.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Leslie, that was the first one, so it supports new model for care. I didn't try to narrow it to something in a piece of law…

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Okay, great.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

…but, the concepts are team-based, outcomes oriented and population management, which are very new from our current status.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Population management.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Thank you, Paul.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Paul, this is Amy and one thing you said in the beginning when you started was, we want to use this drive capabilities in the EHR and it's a floor. I would add one more thing to that statement, not only do we want to drive capabilities; I think we want to be really clear we want to drive use. There are a lot of tools that people have access to and they use whether it's stones or whatever, or computers that they'll use only limited capabilities. So even if it's the floor, and even if it's including the capability, which has to come first, I think that what we're trying to do is drive use to support all of those other items that you talked about, and I would just hate to get that lost.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

No, of course, that's the name of the program. No, good point, good point. Which also speaks to why it has to be…we have to really consider the floor aspect, because if you're going to force people to…you're trying to force people to use, it's got to be in everybody's best interest, primarily the patients, that use of this derives good value. So, we have to be very parsimonious and cautious, as we require things.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Right, so, I didn't mean to mean that you didn't imply it, I just think we want to be very explicit about stating it as well.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

That's right, exactly. Other comments?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

So Paul, when you state it like…again, this would give us some specific…like that reconciliation process, we acknowledge it needs to be more holistic, yet we've got them individualized to kind of go in that direction. And even to reconcile a problem is a challenge in itself. Do we leave that to market forces, do we give…like we were going to kind of break it down maybe a little.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, I don't…and unfortunately, I don't think that is being taken care of by the market, that's just one person's opinion.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah, I think it's really hard.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

And, yeah, and that having a screen or a button that you click to say, oh, what's in that organization and then another one that you click, oh, what's in this other organization and what's in my…that's not what I would consider a tool to help a poor human reconcile all of that. Having it on one's screen and being able to incorporate things, or reject things, from your working device, this is the micro-point, so, a problem list…an individual specialists, which includes primary care, view of the world is what they're trying…but they don't want to ignore or not know about the other things that it says along in that person's view of the problem list. So, we just need those tools. So I think part of being holistic is to say, instead of creating all these separate pieces of function, we want to look at what's useful to the human professional in doing the best possible job influencing their decision about this individual. And that can only be viewed when you look at it holistically rather than as separate functions. And to what you did with your preamble, if we present where we're headed, that's the roadmap, and that's the what's it going to do for you, the provider or you the patient, will be more successful, I think.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Yeah…

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

So, let me put that down in words and maybe pare them from six to like four, and then maybe Michelle, if we have columns, so just check off columns, so we go through each of the subgroups and say, okay, have we made sure that this is…this does support the new model of care, it addresses the national priorities, that has…just as a test. Now, it doesn't have to do all of the things, but we can't have these orphan things where it's really nice and aspirational, but it's just…the standards aren't there or it's really…does it really apply to everybody. Those kinds of things, because we're not the only game in town, the products will evolve, providers will find out what they need to do in order to take care of a population. We just want to be there to support them and to move them…you know, raise the tides to float all the boats. Does that make…is that even a good aspirational goal as far as our work?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

You know Paul, I can kind of make the comment, the market force, one if we get that kind of container that Eva was talking about, work, then I think that collaborative piece that we envisioned, could be market force driven.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Exactly right. So, that's why I really like the…

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs

Just leave the vision up there, but then start to work at what pieces need to be in our container.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

That's right. And ideally, the floor we work on, just like health information exchange, no vendor wanted to do it on their own because it would just be cost to them, but they recognized the value. The public good, the regulation has to happen where you level the playing field for everybody. If everybody's required to do this work of exchange, then the whole tide will rise. So, we want to pick on those things, just like you said, so, collaborative white space, getting the container so no vendor's going to work on that themselves, getting the container with the appropriate information in there, the minimum amount of information in there, will then allow these "apps" to be developed. And that's what we want to see.

So, what we'll try to do is we'll put together this matrix as a tool for you to look…to help reconsider, and particularly this care coordination we went over, is how do we write it so that it addresses these criteria and moves the country in direction towards a destination, without being overbearing or overwhelming. That's the challenge. We'll do that for all of the workgroups and that will be our tool to look at it in our next couple of meetings and sort of how do we consolidate or pare down or create the opportunities for innovation in the context of meaningful use. The next call we need to finish up with subgroup 3 and do 4 and really, I hope we start doing this consolidation pruning sort of right-sizing of the whole Stage 3 objectives.

Arthur Davidson – Denver Public Health Department - Director

Paul, when is that next call when we would do subgroup 4?

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

That is on July 18.

Arthur Davidson – Denver Public Health Department – Director

Okay, so if there's any report on the 10th, it just won't include subgroup 4.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

No, no, there's not report on the 10th.

Arthur Davidson – Denver Public Health Department – Director

Okay.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, so August the first is the first time we're presenting and we want to bring it in as good a form as possible because we won't have that much time for discussion, so we want to put our best effort, in terms of what's the consolidated, parsimonious set that moves the direction in a direction towards the destination we've described.

Arthur Davidson – Denver Public Health Department – Director

So those points that you were making, you're going to summarize and then send out to us.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct. Correct.

Arthur Davidson – Denver Public Health Department – Director

Okay, that would be helpful. I might try to use those as I finalize in preparation for the 18th.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

That would be wonderful, thank you. Thank you Art. Any other final comments before we go to public comment?

George Hripcsak – Columbia University

On the 18th, I would start with group 4 and then finish up with group 3 is the way I'd order it.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

George Hripcsak – Columbia University

Just to make sure we get to group four once.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

George Hripcsak – Columbia University

Okay.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, operator, you want to open up to public comments please.

Public Comment

Rebecca Armendariz – Altarum Institute

If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press *1. Or if you are listening via your telephone, you may press *1 at this time to be entered into the queue. We have no comment at this time.

Paul Tang, MD – Palo Alto Medical Foundation – Internist, VP & CMIO

Thank you very much. Well thank you all for participating and look forward to talking to you on the 18th and then the 27th and finalizing some of these preliminary recommendations that we present to the full committee on the first. Thanks.

George Hripcsak – Columbia University

Thank you Paul.

MacKenzie Robertson – Office of the National Coordinator

Thanks everybody.